

# Kansas Addiction Summit II Claims and PaySpan FAQ

## 1. Can we bill AAPS for spenddown members?

Yes, but the amount paid with AAPS dollars cannot be applied to spenddown. The provider has the option of billing under AAPS and receiving an AAPS payment (or having the claim prepaid if the total AAPS dollars has been paid out) or billing under "Medicaid" and having the charges applied against spenddown. As long as the member is under spenddown the provider may bill the member the amount applied to spenddown.

## 2. Do we have to add the last four digits of the social security number to bill claims?

No. The claim will not pay if you do this. You should bill either the Medicaid ID or the AAPS member number. A good reference to use is the Provider Summary Voucher (PSV) once it has been received; the PSV will have the "correct" member ID that needs to be used on the claims.

## 3. What is an eligibility file?

For Medicaid members: a list of all of the people eligible to receive services reimbursable to Medicaid.

For AAPS members: demographic information entered into the KCPC at the time of the assessment

## 4. What does spenddown mean?

The Medically Needy program offers coverage to people who have income over the maximum allowable income standard. The spenddown amount is your share of your family's medical bills. The spenddown amount is like an insurance deductible. If you have a spenddown amount (deductible), you are responsible for that amount and we would pay any medical bills over that amount.

## 5. Does spenddown also apply to adolescents?

No, however it can apply to the parents of an adolescent.

## 6. How do we know when a member has spenddown?

Check KMAP for the spenddown indicator. Please see the next page for an example.

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Address <https://www.kmap-state-ks.us/PROVIDER/Eligibility/recipients.asp?>  
 Monday 23 August 2010 1:00 pm

## Beneficiary Eligibility Verification

**Beneficiary ID Search**  
 ID:

OR

**SSN Search**  
 SSN:  AND/OR Date of Birth:

OR

**Name Search**  
 Last:  First:  Date of Birth:

From Date of Service:  To Date of Service:

Verification No. 1023522684 - 8/23/2010 - Status: A

**Beneficiary**

ID.	00	Last Name	First Name	Middle Initial	D
SSN		Medicare HIC	Sex	M	
Date of Birth		Date of Death	<a href="#">Copay</a>		
Frames Paid Date		Lens Paid Date	Eye Exam Paid Date		
Psychological Testing		Psychotherapy	Remaining Spenddown Amount	3913.40	
Medicare A	04/01/2010 - 04/30/2010				
Medicare B	04/01/2010 - 04/30/2010				
Medicare D	04/01/2010 - 04/30/2010				

[KPH](#)

## 7. Will we be in trouble if we are paid under two different member numbers for the same person?

No as long as the payments are not for the exact same service, at the same time, on the same day. This should only apply to AAPS funded members. If you find you have received reimbursement for the same member, same service and same date of service but each payment was received under different member numbers please contact either your Provider Relations (PR) Rep or Customer Service to report the overpayment. The claim department will be notified by either of these departments with a request to recoup the overpayment and we will make a notation on the "incorrect" member account in the event we receive claims under this member ID again, and we will automatically redirect the claim to the correct member ID.

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- 8. What do we do if a person's Block Grant information was put in wrong and now we have the right information? Is it considered fraudulent if we know the correct information and use the wrong information because that's what is in the system?**

At the present time, please write the correct information into the continued stay review. For billing purposes, the incorrect information will need to be used because that is the information which was used to create the Block Grant member identification number. For the purpose of Block Grant billing, this is not considered fraudulent billing; it is merely a limitation of the current authorization system.

- 9. Do we have to submit an EOB on every member or just the first claim?**

Yes, if the member has other health insurance, you must submit the Explanation of Benefits (EOB) for every claim. If the primary carrier will never cover the service we request an EOB from the primary carrier with this denial. We can then notate our system and accept additional claims without the primary carrier's denial. Should the primary carrier ever change we would require an EOB from the new primary insurance company.

- 10. What do we do if we don't get the primary EOB in time?**

If the member has other health insurance, you need to bill that insurance carrier first. Once you receive an EOB from the other health insurance company, you have 90 days from the date of the EOB to bill ValueOptions. Please be sure to attach the EOB to the claim.

- 11. Can we have these examples electronically?**

Yes. A copy of this presentation will be available at [http://www.valueoptions.com/kansas/providers/prv\\_information.htm](http://www.valueoptions.com/kansas/providers/prv_information.htm)

- 12. Do we need to update the KCPC unique id with the social security number and put it back in the KCPC?**

No.

- 13. What happens if our biller leaves and we set her up as an administrator on PaySpan?**

You should have two administrators so you will always have one to handle that can setup a new one. I would not recommend a biller being an administrator. Remember administrators have the highest level of security.

- 14. Will you notify the provider about why we're reversing the claim?**

Remittance Advice (RA) explanation: whenever claims are reversed we attach an adjustment code to the reversed line so you know why the claim

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is being reversed. The adjustment code should be printing on the RA; please let us know and provide examples if they are not printing.

### **15. Will billing at the higher rate slow down claims payment?**

No. Billing ValueOptions for a higher rate than the fee schedule allows will not slow down claims payment. ValueOptions strongly recommends setting a standard rate for the services provided within your organization and billing that rate even if it is higher than the fee schedule.

ValueOptions will only pay up to the fee schedule rate.

The only difference you will see when billing a rate higher than the fee schedule is that on the PSV you will receive an "IR" Explanation of Payment (EOP) code with the EOP description of

BILLED AMOUNT EXCEEDS FEE SCHEDULE RATE. IN NETWORK SERVICES ARE ONLY PAID AT THE MAXIMUM FEE SCHEDULE AMOUNT FOR THIS PARTICULAR SERVICE. TO NO LONGER RECEIVE THIS MESSAGE PLEASE SUBMIT YOUR BILLED CHARGES FOR THE MAXIMUM FEE SCHEDULE AMOUNT.

### **16. Is there a way that the claims software dates of service can be changed to not default to the year 1980?**

We will research this issue.

### **17. On spenddown, is there a difference between outpatient and residential when applying the dollars?**

Residential dollars should not be applied against spenddown.

### **18. Is there a billing system PaySpan will support?**

You will need to contact PaySpan customer service for this information at 877-331-7154.